The Garamendi Plan
Bridging the Gap Between Workers and Employers
Completing Workers' Compensation Reform

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The Garamendi Plan
Solutions for California's Workers' Compensation Crisis

Permanent Partial and Total Disability (PD)

- Use an independent medical examiner for determination of permanent impairment, compensability, and medical treatment in disputed cases.
- Pay Permanent Disability at the same rate as Temporary Disability for greater efficiency and in order to expedite Permanent Disability payments to injured workers.
- Create a more standardized and consistent method to determine the extent of impairment using the American Medical Association (AMA) guidelines.
- Address apportionment so that an employer does not pay a second time for permanent disability that has already been awarded.

Immediate Benefits for Injured Workers

- Make the employer responsible for providing immediate workers' compensation benefits (indemnity and medical treatment) to all injured workers injuries until the claim is denied, with the exception of cumulative trauma cases where the 90-day accept/deny rule will remain.
- Extend the current 90-day time limit for employers to deny claims to one year. Employers can deny a claim for fraud at any time. If fraud is proved, the employer is entitled to restitution. An expedited hearing will immediately follow any challenge to a claim.

Effective and Efficient Medical Treatment

- Require physicians to utilize the descriptions and procedures set forth in the AMA guides and medical treatment guidelines in order to standardize medical reporting.
- Collect medical billing data to identify medical billing and treatment abuse by providers.
- Require timely completion of medical-legal evaluations.
- Mandate training on the medical treatment guidelines for qualified medical evaluators.
- Establish a strong definition of reasonable medical treatment by defining the requisite medical treatment necessary to cure and relieve an injured worker.
- Penalize medical providers who consistently bill in excess of the official medical fee schedule.
- Develop a streamlined independent medical review process that incorporates an examination by an independent medical examiner (IME) to determine compensability, permanent disability, and medical treatment.
- Index physician fees to Medicare/Resource Based Relative Value Scale on a cost-neutral basis (115% of Medicare) to create a consistent, predictable, familiar, cost-efficient and easily updateable payment standard. Provide for periodic review and revision.

Anti-Fraud Measures

- Make uninsured employers subject to felony charges.
- Strengthen the ability of CDI and the district attorneys to identify and prosecute uninsured employers.
- Provide immunity for individuals reporting suspected fraud.
- Include the cost of investigation in penalties for workers' compensation insurance fraud.
- Allow workers' compensation insurance fraud investigators to utilize search warrants to obtain evidence of fraud.

State Compensation Insurance Fund (SCIF or State Fund) Reform

- Add two more voting members to the SCIF Board (raising the voting member total from 5 to 7 members) and exempt new board members from the SCIF policyholder requirement in order to allow recruitment of specialized expertise and fresh perspectives for SCIF management and oversight.
- Clarify that the Insurance Commissioner's existing authority over State Fund is the same as over any other workers' compensation insurance company.

Irrational Penalty Structure

- Allow for disputes on unreasonably refused or delayed benefits to be resolved either through payment of an immediate no-fault penalty or, if litigated, increase penalties to 25% on the amount in dispute or $500, whichever is greater.

Return to Work

- Require employers who have experience rating to provide to treating physicians descriptions of the physical requirements of the job, as well as the physical requirements of any alternate, modified, or light duty work. Require physicians to report on the ability of the injured worker to return to regular, alternate, modified, or light duty work.
- Allow employers to obtain reimbursement for worksite modifications.
- Repeal the treating physician's presumption for pre-designated physicians regarding medical treatment.
- Establish disability duration norms for most common work injuries and incorporate them into medical treatment utilization schedules.

Regulation and Assessment

- Regulate minimum loss cost insurance rates to stabilize the insurance market and pass through reform savings to policyholders.
- Bring back the uniform classification system.
- Assess deductible policies to bolster CIGA and to bring more equity to policyholders

Integrated System Carve Out Pilot

- Establish a pilot program for qualifying carve-outs to integrate health and disability benefit delivery.
- Empower CHSWC to gather data to provide objective findings on effects of program on quality of care, costs, amount of litigation, etc.
- Sunset in 2010 unless CHSWC report indicates success.

PERMANENT DISABILITY

Problem: The current system for determining an injured worker's level of disability (PD, PPD, TD) is highly subjective and inconsistent leading to increased litigation and irrational settlements in which small injuries receive too much and serious injuries too little. Similar injuries should receive consistent PD ratings. This is not currently the case in California's PD rating system.

Solution: California must develop a more equitable and consistent permanent disability rating system based on objective assessments of disability. Restructuring permanent disability must be the top priority for 2004 workers' compensation reform. This can be done by (1) creating a more standardized and consistent method for the determination of impairment, and (2) reducing the frictional costs in the dispute resolution process by incorporating an independent medical examiner. Both of these changes will simplify the system, generate more equitable, efficient and timely PD settlements, and lead to dramatically lower levels of litigation within the system. The Rand Study on PD commissioned by CHSWC (expected Feb. 2004) will provide the foundation for a more efficient method of determining impairment. The Legislature should take immediate action on legislation to improve the current system once this study is complete. PD reform should also address apportionment. An employer should not have to pay a second time for permanent disability that has already been awarded.

Labor Code Sections 4060, 4061, 4062, 4062.01, 4062.3

Independent Medical Exam

Sec. _____. Section 4060 of the Labor Code is amended to read:

4060. (a) This section shall apply to disputes over the compensability of any injury. This section shall not apply ~~where~~ when injury to any part or parts of the body is accepted as compensable by the employer.

(b) Neither the employer nor the employee shall be liable for any comprehensive medical-legal evaluation performed by other than the treating physician either in whole or in part on behalf of the employee prior to the filing of a claim form and prior to the time the claim is denied or becomes presumptively compensable under Section 5402. However, reports of treating physicians shall be admissible.

(c) If a medical evaluation is required to determine compensability at any time after the period specified in subdivision (b), and the employee is represented by an attorney, ~~each party may select a qualified medical evaluator to conduct a comprehensive medical-legal evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The parties may, at any time, agree on one medical evaluator to evaluate the issues in dispute.~~ the party disputing compensability shall notify the other party in writing regarding the dispute. The parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10

days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator, and either of the parties may only request an independent qualified medical evaluator from the medical director.

(d) If a medical evaluation is required to determine compensability at any time after the period specified in subdivision (b), and the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare a comprehensive medical-legal evaluation ~~The employee may select a qualified medical evaluator to prepare a comprehensive medical-legal evaluation. The division shall assist unrepresented employees, and shall make available to them the list of medical evaluators compiled under Section 139.2. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense.~~ , and either of the parties shall immediately request an independent qualified medical evaluator from the medical director to address the disputed issues. If an employee has received a comprehensive medical-legal evaluation under this subdivision, and he or she later becomes represented by an attorney, he or she shall not be entitled to an additional evaluation ~~at the employer's expense~~.

(e) The medical director shall within 10 days of receipt of the request for medical evaluation select a qualified medical evaluator who is competent to evaluate the compensability issues and immediately notify the employee, the employer, and their representatives in writing as to the name, mailing address, and telephone number of the qualified medical evaluator appointed and send notice to the qualified medical evaluator as to his or her selection.

(f) The employer shall provide to the agreed medical evaluator or qualified medical evaluator designated by the medical director a copy of all documents necessary to conduct the medical evaluation, pursuant to regulations promulgated by the administrative director, within 10 business days of agreement by the parties on the agreed medical evaluator or receipt of the notice of the selected qualified medical evaluator**.** The employer shall concurrently provide a copy of medical records required by this paragraph, if not previously provided, and an annotated list and copies of all other documents, submitted to the qualified medical evaluator to the employee, or his or her representative.

(g) The employer shall immediately arrange with the office of the agreed medical evaluator or qualified medical evaluator selected by the medical director for a medical examination date and time and send notice of the date, time and place of the examination to the employee with applicable mileage reimbursement.

~~(e)~~ (h) Evaluations performed under this section shall not be limited to the issue of the compensability of the injury, but shall address all medical issues in dispute.

(i)The confidentiality of any employee medical information shall be maintained by the division and the agreed or qualified medical evaluator as required by applicable state and federal laws. The division and the agreed or qualified medical evaluator shall maintain the confidentiality of any information found by the administrative director to be the proprietary information of the employer. However, the employee may waive confidentiality by signing a release, particularly for the purpose of providing the employer with information necessary to provide modified work.

(j) The determinations of the agreed or independent qualified medical evaluators shall be presumed correct and the presumption is one affecting the burden of proof.

Sec. _____. Section 4061 of the Labor Code is amended to read:

4061. (a) Together with the last payment of temporary disability indemnity, the employer shall, in a form prescribed by the administrative director pursuant to Section 138.4, provide the employee one of the following:
(1) Notice either that no permanent disability indemnity will be paid because the employer alleges the employee has no permanent impairment or limitations resulting from the injury or notice of the amount of permanent disability indemnity determined by the employer to be payable. The notice shall include information concerning how the employee may obtain a formal medical evaluation pursuant to subdivision (c) if he or she disagrees with the position taken by the employer. The notice shall be accompanied by the form prescribed by the administrative director for requesting assignment of ~~a panel~~ of an independent qualified medical evaluators~~,~~, unless the employee is represented by an attorney. If the employer determines permanent disability indemnity is payable, the employer shall advise the employee of the amount determined payable and the basis on which the determination was made and whether there is need for continuing medical care.
(2) Notice that permanent disability indemnity may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time the necessary evaluation will be performed to determine the existence and extent of permanent impairment and limitations for the purpose of rating permanent disability and to determine the need for continuing medical care, or at which time the employer will advise the employee of the amount of permanent disability indemnity the employer has determined to be payable. If an employee is provided notice pursuant to this paragraph and the employer later takes the position that the employee has no permanent impairment or limitations resulting from the injury, or later determines permanent disability indemnity is payable, the employer shall in either event, within 14 days of the determination to take either position, provide the employee with the notice specified in paragraph (1).

(b) Each notice required by subdivision (a) shall describe the administrative procedures available to the injured employee and advise the employee of his or her right to consult an information and assistance officer or an attorney. It shall contain the following language:
"Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits."

(c) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation or the assessment of need for continuing medical care, and the employee is represented by an attorney, the employer shall seek agreement with the employee or the employee's attorney on a physician to prepare a comprehensive medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care

resulting from the injury. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed to by the parties, the parties may not later select an agreed medical evaluator. Evaluations of an employee's permanent impairment and limitations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, either ~~party~~ of the parties may ~~select a~~ only request an independent qualified medical evaluator from the medical director to conduct the comprehensive medical evaluation. ~~Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense.~~

(d) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation, and if the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare an additional medical evaluation. The employer shall immediately ~~provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury.~~ request an independent qualified medical evaluator from the medical director to address the disputed issues. If an employee has received a comprehensive medical-legal evaluation under this subdivision, and he or she later becomes represented by an attorney, he or she shall not be entitled to an additional evaluation. For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the report of the qualified medical evaluator and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or the employer on the issues subject to this section.

~~(e) If an employee obtains a qualified medical evaluator from a panel pursuant to subdivision (d) or pursuant to subdivision (b) of Section 4062, and thereafter becomes represented by an attorney and obtains an additional qualified medical evaluator, the employer shall have a corresponding right to secure an additional qualified medical evaluator.~~
~~(f) The represented employee shall be responsible for making an appointment with an agreed medical evaluator.~~
~~(g) The unrepresented employee shall be responsible for making an appointment with a qualified medical evaluator selected from a panel of three qualified medical evaluators. The evaluator shall give the employee, at the appointment, a brief opportunity to ask questions concerning the evaluation process and the evaluator's background. The unrepresented employee shall then participate in the evaluation as requested by the evaluator unless the employee has good cause to discontinue the evaluation. For purposes of this subdivision, "good cause" shall include evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion, or sexual preference or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure. If the unrepresented employee declines to proceed with the evaluation, he or she shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a comprehensive medical evaluation. If the appeals board subsequently determines that the employee did not have good cause to not proceed with the evaluation, the cost of the evaluation shall be deducted from any award the employee obtains.~~

(e) The medical director shall within 10 days of receipt of the request for medical evaluation select an independent qualified medical evaluator who is competent to evaluate the specific disability and medical treatment issues and immediately notify the employee, the employer, and their representatives in writing as to the name, mailing address, and telephone number of the qualified medical evaluator appointed and send notice to the qualified medical evaluator as to his or her selection.

(f) The employer shall provide to the agreed medical evaluator or qualified medical evaluator designated by the medical director a copy of all documents necessary to conduct the medical evaluation, pursuant to regulations promulgated by the administrative director, within 10 business days of agreement by the parties on the agreed medical evaluator or receipt of the notice of the selected qualified medical evaluator**.** The employer shall concurrently provide a copy of medical records required by this paragraph, if not previously provided, and an annotated list and copies of all other documents, submitted to the qualified medical evaluator to the employee, or his or her representative.

(g) The employer shall immediately arrange with the office of the agreed medical evaluator or qualified medical evaluator selected by the medical director for a medical examination date and time and send notice of the date, time and place of the examination to the employee with applicable mileage reimbursement.

(h) Upon selection or assignment pursuant to subdivision (c) or (d), the medical evaluator shall perform a comprehensive medical evaluation according to the procedures promulgated by the administrative director under paragraphs (2) and (3) of subdivision (j) of Section 139.2 and summarize the medical findings on a form prescribed by the administrative director. The comprehensive medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a comprehensive medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(i) Except as provided in Section 139.3, the medical evaluator may obtain consultations from other physicians who have treated the employee for the injury whose expertise is necessary to provide a complete and accurate evaluation.

(j) The independent qualified medical evaluator who has evaluated an unrepresented employee shall serve the comprehensive medical evaluation and the summary form on the employee, employer, and the administrative director. The unrepresented employee or the employer may submit the treating physician's evaluation for the calculation of a permanent disability rating. Within 20 days of receipt of the comprehensive medical evaluation, the administrative director shall calculate the permanent disability rating according to Section 4660 and serve the rating on the employee and employer.

(k) Any comprehensive medical evaluation concerning an unrepresented employee which indicates that part or all of an employee's permanent impairment or limitations may be subject to apportionment pursuant to Sections 4663 or 4750 shall first be submitted by the administrative director to a workers' compensation judge who may refer the report back to the independent qualified medical evaluator for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law.

(l) Within 30 days of receipt of the rating, if the employee is unrepresented, the employee or employer may request that the administrative director reconsider the recommended rating or obtain additional information from the treating physician or medical evaluator to address issues not addressed or not completely addressed in the original comprehensive medical evaluation or not prepared in accord with the procedures promulgated under paragraph (2) or (3) of subdivision (j) of Section 139.2. This request shall be in writing, shall specify the reasons the rating should be reconsidered, and shall be served on the other party. If the administrative director finds the comprehensive medical evaluation is not complete or not in compliance with the required procedures, the administrative director shall return the report to the treating physician or independent qualified medical evaluator for appropriate action as the administrative director instructs. Upon receipt of the treating physician's or independent qualified medical evaluator's final comprehensive medical evaluation and summary form, the administrative director shall recalculate the permanent disability rating according to Section 4660 and serve the rating, the comprehensive medical evaluation, and the summary form on the employee and employer.

(m) If a comprehensive medical evaluation from the treating physician or an agreed medical evaluator or ~~a~~ an independent qualified medical evaluator ~~selected from a three-member panel~~ resolves any issue so as to require an employer to provide compensation, the employer shall commence the payment of compensation or promptly commence proceedings before the appeals board to resolve the dispute. If the employee and employer agree to a stipulated findings and award as provided under Section 5702 or to compromise and release the claim under Chapter 2 (commencing with Section 5000) of Part 3, or if the employee wishes to commute the award under Chapter 3 (commencing with Section 5100) of Part 3, the appeals board shall first determine whether the agreement or commutation is in the best interests of the employee and whether the proper procedures have been followed in determining the permanent disability rating. The administrative director shall promulgate a form to notify the employee, at the time of service of any rating under this section, of the options specified in this subdivision, the potential advantages and disadvantages of each option, and the procedure for disputing the rating.

(n) No issue relating to the existence or extent of permanent impairment and limitations or the need for continuing medical care resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician or an agreed or independent qualified medical evaluator. With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations or need for continuing medical care resulting from the injury shall be obtained prior to service of the comprehensive medical evaluation on the employee and employer if the employee is unrepresented, or prior to the attempt to select an agreed medical evaluator if the employee is represented. Evaluations obtained in violation of this prohibition

shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury and comprehensive medical evaluations prepared by ~~a~~ an independent qualified medical evaluator ~~selected by~~ of an unrepresented employee ~~from a three-member panel~~ shall be admissible.

(o) Evaluations performed under this section shall address all medical issues in dispute.

(p) The confidentiality of any employee medical information shall be maintained by the division and the agreed or independent qualified medical evaluator as required by applicable state and federal laws. The division and the agreed or independent qualified medical evaluator shall maintain the confidentiality of any information found by the administrative director to be the proprietary information of the employer. However, the employee may waive confidentiality by signing a release, particularly for the purpose of providing the employer with information necessary to provide modified work.

(q) The determinations of the agreed or independent qualified medical evaluators shall be presumed correct and the presumption is one affecting the burden of proof.

SEC. ___. Section 4062 of the Labor Code is amended to read:

4062. (a) This section shall not apply to disputes concerning the extent and scope of medical treatment or disputed medical treatment, which are subject to the medical evaluation process set forth in sections 4615 through 4617, inclusive.

~~(a)~~ (b) If either the employee or employer objects to a medical determination made by the treating physician concerning the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, ~~the extent and scope of medical treatment,~~ the existence of new and further disability, or any other medical issues not covered by Section 4060 or 4061 or not subject to the medical evaluation process as set forth in sections 4615 through 4617, inclusive, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. ~~Employer objections to the treating physician's recommendation for spinal surgery shall be subject to subdivision (b), and after denial of the physician's recommendation, in accordance with Section 4610.~~ These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain

additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation.

~~(b) The employer may object to a report of the treating physician recommending that spinal surgery be performed within 10 days of the receipt of the report. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a second opinion report resolving the disputed surgical recommendation. If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the administrative director to prepare a second opinion report resolving the disputed surgical recommendation. Examinations shall be scheduled on an expedited basis. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report. If the second opinion report recommends surgery, the employer shall authorize the surgery. If the second opinion report does not recommend surgery, the employer shall file a declaration of readiness to proceed. The employer shall not be liable for medical treatment costs for the disputed surgical procedure, whether through a lien filed with the appeals board or as a self-procured medical expense, or for periods of temporary disability resulting from the surgery, if the disputed surgical procedure is performed prior to the completion of the second opinion process required by this subdivision.~~

~~(c) The second opinion physician shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:~~
~~(1) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.~~

~~(2) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.~~

~~(3)A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.~~

~~(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.~~

~~(5)The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.~~

~~(6) The employee or the employee's immediate family.~~

~~(d)~~ (c) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. ~~Except in cases where the treating physician's recommendation that spinal surgery be performed pursuant~~

~~to subdivision (b), the~~ The employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a comprehensive medical evaluation. For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.

~~(e)~~ (d)Upon completing a determination of the disputed medical issue, the physician selected under subdivision ~~(a)~~ (b) or ~~(d)~~ (c) to perform the medical evaluation shall summarize the medical findings on a form prescribed by the administrative director and shall serve the formal medical evaluation and the summary form on the employee and the employer. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

~~(f)~~ (e) No disputed medical issue specified in subdivision ~~(a)~~ (b) may be the subject of a declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.

(g) With the exception of a report or reports prepared by the treating physician or physicians, no report determining disputed medical issues set forth in subdivision ~~(a)~~ (b)shall be obtained prior to the expiration of the period to reach agreement on the selection of an agreed medical evaluator under subdivision ~~(a)~~ (b). Reports obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury shall be admissible.

~~(h) This section shall remain in effect only until January 1, 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2007, deletes or extends that date.~~

(h) The confidentiality of any employee medical information shall be maintained by the division and the agreed or independent qualified medical evaluator as required by applicable state and federal laws. The division and the agreed or independent qualified medical evaluator shall maintain the confidentiality of any information found by the administrative director to be the proprietary information of the employer. However, the employee may waive confidentiality by signing a release, particularly for the purpose of providing the employer with information necessary to provide modified work.

(i) The determinations of the agreed or independent qualified medical evaluators shall be presumed correct and the presumption is one affecting the burden of proof.

SEC. ___. Section 4062.01 of the Labor Code is repealed

SEC. ___. Section 4062.3 of the Labor Code is added to the Labor Code to read:

The independent qualified medical evaluator selected by the medical director pursuant to Sections 4060, 4061, or 4062 shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:
(a) The employer, his or her workers' compensation insurer, third-party claims administrator, or other entity contracted to provide utilization review services pursuant to Section 4610.

(b) Any officer, director, or employee of the employer's health care provider, workers' compensation insurer, or third-party claims administrator.

(c)A physician, the physician's medical group, or the independent practice association involved in the health care service in dispute.

(d) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer's health care provider, workers' compensation insurer, or third-party claims administrator, would be provided.

(e)The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee or his or her treating physician whose treatment is under review, or the alternative therapy, if any, recommended by the employer or other entity.

(f) The employee or the employee's immediate family.

Labor Code Section 4650(b)

TD and PD Payments at the Same Rate

SEC.___. Section 4650(b) of the Labor Code is amended to read:

"(b) (1) If the injury causes permanent disability, the first payment shall be made within 14 days after the date of last payment of temporary disability indemnity. Where the extent of permanent disability cannot be determined at the date of last payment of temporary disability indemnity, the employer nevertheless shall commence the timely payment required by this subdivision and shall continue to make these payments until the employer's reasonable estimate of permanent disability indemnity due has been paid, and if the amount of permanent disability indemnity due has been determined until that amount has been paid.

(2) When the monetary value of the permanent disability has been determined or estimated, the payment of the permanent disability indemnity shall be made at the same weekly rate as temporary disability indemnity. Along with the first payment of permanent disability, the employer shall provide the employee the notices specified in Section 4061 and the following conspicuous warning in at least 12-point type: "WARNING: Your permanent disability

indemnity is paid at the same weekly rate as your temporary disability indemnity, and any future payments of permanent disability indemnity may be deducted from the ultimate award or settlement."

(3) Paragraph (2) shall not apply to payments made pursuant to subdivision (a) of Section 4659, relating to the payment of life pensions."

Labor Code Section 4660

Permanent Disability Rating Schedule

SEC. _____. Section 4660 of the Labor Code is amended, to read:

4660. (a) In determining the percentages of permanent disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of ~~such~~ the injury, consideration being given to the diminished ability of ~~such~~ the injured employee to compete in an open labor market.

(b) The administrative director may prepare, adopt, and from time to time amend, a schedule for the determination of permanent disabilities in accordance with this section. ~~Such~~ This schedule shall be available for public inspection, and without formal introduction in evidence shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule.

(c) Any ~~such~~ schedule and any amendment ~~thereto~~ or revision ~~thereof~~ of the schedule shall apply prospectively and shall apply to and govern only those permanent disabilities ~~which~~ that result from compensable injuries received or occurring on and after the effective date of the adoption of ~~such~~ that schedule, amendment, or revision, as the fact may be.

(d) On or before January, ~~1995~~ 2006, the administrative director shall review and revise the schedule for the determination of the percentage of permanent disabilities in consultation with Commission on Health and Safety and Workers' Compensation. The ~~revision shall include, but not be limited to, an updating of the standard disability ratings and occupations to reflect the current labor market~~ revised schedule shall be based upon the objective descriptions and measurements of physical impairments used in the most recent edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment. However no change in standard disability ratings shall be adopted without the approval of the Commission of Health and Safety and Workers' Compensation. A proposed revision shall be submitted to the commission on or before July 1, ~~1994~~ 2005.

Labor Code Sections 4663, 4664, 4750, 4750.5

Apportionment

(1) Limiting the rule barring "retroactive" prophylactic restrictions.

(2) Precluding a single employee from receiving PD awards exceeding 100 percent over his or her lifetime.

(3) Restricting the rule of *Wilkinson v WCAB* (1977) 19 C3d 491, 138 CR 696, 42 CCC 406 authorizing combining permanent disabilities that become permanent and stationary at the same time and rating the combined disability as if it were caused by a single injury with compensation payable according to the law in effect on the date of the last injury.

(4) Creating a presumption that a permanent disability once determined will continue to exist at the time of any subsequent industrial injury.

(5) Nullifying the rule of *Ashley v WCAB* (1995) 37 CA4th 320, 23 CWCR 216, 60 CCC 683, that one may not apportion to subsequent non-industrial conditions.

SEC. _. Section 4663 of the Labor Code is amended to read:

4663. (a) In case of aggravation of any disease existing prior to a compensable injury, compensation shall be allowed only for the proportion of the disability due to the aggravation of such prior disease which is reasonably attributed to the injury.

(b) The portion of the disability that would have existed in the absence of the aggravation may be proven by competent medical evidence that the preexisting disease would have caused work limitations in the absence of the injury. The opinion of a physician that did not examine the injured employee before the injury is competent medical evidence if based on an accurate history, adequate medical observation, and knowledge of the disease condition disclosed by surgery, diagnostic testing, or imaging.

(c) The fact that the pre-existing disease was neither symptomatic nor disabling does not preclude apportionment under this section.

SEC. _. Section 4664 is added to the Labor Code, to read:

4664. The total of all permanent disability awards made in favor of an employee shall not exceed 100 percent unless the disability from one or more of the injuries is conclusively presumed to be total pursuant to Section 4662.

SEC. _. Section 4750 of the Labor Code is amended to read:

4750. (a) An employee who is suffering from a previous permanent disability or physical impairment and sustains permanent injury thereafter shall not receive from the employer compensation for the later injury in excess of the compensation allowed for such injury when considered by itself and not in conjunction with or in relation to the previous disability or impairment.

(b) A previous permanent disability or physical impairment determined by a final decision in a proceeding before the appeals board or other tribunal shall be presumed to exist at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof and may be controverted by medical evidence that fully discusses the issue of apportionment, sets forth the basis of the medical opinion, and explains the medical processes by which the previous disability or impairment resolved.

(c) The employer shall not be liable for compensation to such an employee for the combined disability, but only for that portion due to the later injury as though no prior disability or impairment had existed.

(d) When two or more injuries cause successive permanent disabilities, the percentage of disability caused by each injury shall be independently determined, and the employer at the time of each injury shall be liable only for the number of weeks of permanent disability indemnity provided by Section 4658 for that injury.

SEC. _. Section 4750.5 of the Labor Code is amended to read:

4750.5. An employee who has sustained a compensable injury and who subsequently ~~sustains~~ suffers an unrelated noncompensable ~~injury~~ disability, shall not receive permanent disability indemnity for any permanent disability caused ~~solely~~ by the subsequent noncompensable ~~injury~~ disability.

The purpose of this section is to overrule the decision in Jensen v. WCAB, 136 Cal. App. 3d 1042.

IMMEDIATE BENEFITS FOR INJURED WORKERS

Problem: For countless reasons, injured workers are too frequently denied the immediate, essential, and, often, basic medical treatment and indemnity benefits they are entitled to under the workers' compensation system. In nine out of ten cases, the injured worker is ultimately granted the medical care they or their physician initially requested. These unnecessary delays in benefit payments and medical treatment lead to unnecessary costs (increased medical, indemnity, and litigation). As untreated workers' medical conditions worsen, they take much longer to return to work, and they seek legal counsel to resolve the issues.

Solution: The employer must be responsible for providing immediate workers' compensation benefits (indemnity and medical treatment) to all injured workers. Employers will have up to one year to deny a claim as opposed to the current 90 day period. Employers should be able to deny a claim for fraud at any time. If fraud is proved, the employer is entitled to restitution. Employers will be responsible for all compensation benefits for specific injuries until the claim is denied.

Labor Code section 5402

Liability Prior to Rejection of Liability; Time for Rejection; Time for Rejection with Allegation of Fraud

SEC. ___. Section 5402 of the Labor Code is amended to read:

5402. (a) Knowledge of an injury, obtained from any source, on the part of an employer, his or her managing agent, superintendent, foreman, or other person in authority, or knowledge of the assertion of a claim of injury sufficient to afford opportunity to the employer to make an investigation into the facts, is equivalent to service under Section 5400.

(b) ~~If~~ (1) Until the employer rejects in writing liability for a claim of injury all compensation to which an employee is entitled as a result of an injury shall be promptly provided unless it is alleged that the injury is as a result of cumulative trauma.
(2) As to cumulative trauma injuries, if liability is not rejected within 90 days after the date the claim form is filed under Section 5401, the injury shall thereafter be presumed compensable under this division. ~~The presumption of this subdivision is rebuttable only by evidence discovered subsequent to the 90-day period.~~
(3) As to all other injuries, liability may be rejected and prospective compensation denied at any time within one year after the claim form is filed under Section 5401.
(4) Any time, before or after the one-year period for rejection set forth in paragraph (3), a claim may be denied if the claim of injury is alleged to be a result of fraud.
(5) If the claim is later proved to be fraudulent, an employer shall be entitled to restitution.

(c) If liability is rejected by the employer, the employer shall immediately file a declaration of readiness to proceed and shall request an expedited hearing with the appeals board regarding compensation of the injury.

EFFECTIVE AND EFFICIENT MEDICAL TREATMENT

Problem: Overutilization of medical services is a major cost driver that does not necessarily aid injured workers, extends injury claims, and wastes medical treatment resources. Numerous interstate comparisons and California-specific studies have demonstrated that overutilization of medical treatment is a serious problem within California's workers' compensation system. The 2003 reforms made significant improvements in establishing effective medical utilization controls by implementing evidence-based medical treatment guidelines and placing hard caps on chiropractic and physical therapy treatments. Despite these significant improvements, there is still more that needs to be done to complete the reform.

Solution: To build upon the 2003 reforms, we propose developing a strong definition of "reasonable medical treatment" and a streamlined independent medical review (IMR) process. For the evidence-based clinical treatment guidelines to achieve full effect, they need to be accompanied by a strong definition of "reasonable medical treatment." To reduce litigation and get workers the most appropriate medical care, the new treatment guidelines should be supported by an IMR process where workers' compensation medical decisions are made by medical practitioners. For guidelines to be effective, it is also imperative for medical providers, insurers' claims staff, and Workers' Compensation Appeals Board (WCAB) judges to be quickly and thoroughly trained on implementation of the new medical treatment guidelines. While these evidence-based guidelines will be the accepted standard of treatment, the examiner can consider new or additional scientific evidence of efficacy to approve a treatment that exceeds the guidelines.

Labor Code Sections 139.2(j) and 5703

PD Report Writing and Diagnosis

SEC. _. Subdivision (j) of Section 139.2 of the Labor Code is amended to read:

(j) After public hearing pursuant to Section 5307.3, the administrative director shall adopt regulations concerning the following issues:

(1) Standards governing the timeframes within which medical evaluations shall be prepared and submitted by agreed and qualified medical evaluators. Except as provided in this subdivision, the timeframe for initial medical evaluations to be prepared and submitted shall be no more than 30 days after the evaluator has seen the employee or otherwise commenced the medical evaluation procedure.

The administrative director shall develop regulations governing the provision of extensions of the 30-day period in cases: (A) where the evaluator has not received test results or consulting physician's evaluations in time to meet the 30-day deadline; and, (B) to extend the 30-day period by not more than 15 days when the failure to meet the 30-day deadline was for good cause. For purposes of this subdivision, "good cause" means: (i) medical emergencies of the evaluator or evaluator's family; (ii) death in the evaluator's family; or, (iii) natural disasters or other community catastrophes that interrupt the operation of the evaluator's business. The administrative director shall develop timeframes governing availability of qualified medical

evaluators for unrepresented employees under Sections 4061 and 4062. These timeframes shall give the employee the right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, but shall also permit the employee to waive this right for a specified period of time thereafter.

(2) Procedures to be followed by all physicians in evaluating the existence and extent of permanent impairment and limitations resulting from an injury. In order to produce complete, accurate, uniform, and replicable evaluations, the procedures shall require that ~~an~~ description and evaluation of anatomical loss, functional loss, and the presence of physical complaints be ~~supported, to the extent feasible, by medical findings based on standardized examinations and testing techniques generally accepted by the medical community~~ in accordance with the descriptions and measurements of physical impairments used in the most recent edition of the Guides to the Evaluation of Permanent Impairment of the American Medical Association adopted by the Administrative Director.

(3) Procedures governing the determination of any disputed medical issues. The procedures for determining diagnosis and necessary treatment shall be in accordance with the principles and recommendations in the medical treatment guidelines in effect pursuant to section 4604.5.

(4) Procedures to be used in determining the compensability of psychiatric injury. The procedures shall be in accordance with Section 3208.3 and shall require that the diagnosis of a mental disorder be expressed using the terminology and criteria of the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, ~~Third Edition Revised~~, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

(5) Guidelines for the range of time normally required to perform the following:
(A) A medical-legal evaluation that has not been defined and valued pursuant to Section 5307.6. The guidelines shall establish minimum times for patient contact in the conduct of the evaluations, and shall be consistent with regulations adopted pursuant to Section 5307.6.
(B) Any treatment procedures that have not been defined and valued pursuant to Section 5307.1.
(C) Any other evaluation procedure requested by the Insurance Commissioner, or deemed appropriate by the administrative director.

(6) Any additional medical or professional standards that a medical evaluator shall meet as a condition of appointment, reappointment, or maintenance in the status of a medical evaluator.

SEC. _. Section 5703 of the Labor Code is amended to read:

5703. The appeals board may receive as evidence either at or subsequent to a hearing, and use as proof of any fact in dispute, the following matters, in addition to sworn testimony presented in open hearing:

(a) Reports of attending or examining physicians.

(1) Statements concerning any bill for services are admissible only if made under penalty of perjury that they are true and correct to the best knowledge of the physician.

(2) In addition, reports are admissible under this subdivision only if the physician has further stated in the body of the report that there has not been a violation of Section 139.3 and that the contents of the report are true and correct to the best knowledge of the physician. The statement shall be made under penalty of perjury.

(3) A comprehensive medical evaluation by an attending or examining physician is admissible as evidence only if it complies with the procedures adopted by the administrative director pursuant to paragraphs (2) and (3) of subdivision (j) of Section 139.2.

(b) Reports of special investigators appointed by the appeals board or a workers' compensation judge to investigate and report upon any scientific or medical question.

(c) Reports of employers, containing copies of timesheets, book accounts, reports, and other records properly authenticated.

(d) Properly authenticated copies of hospital records of the case of the injured employee.

(e) All publications of the Division of Workers' Compensation.

(f) All official publications of the State of California and United States governments.

(g) Excerpts from expert testimony received by the appeals board upon similar issues of scientific fact in other cases and the prior decisions of the appeals board upon similar issues.

(h) Relevant portions of medical treatment protocols published by medical specialty societies. To be admissible, the party offering such a protocol or portion of a protocol shall concurrently enter into evidence information regarding how the protocol was developed, and to what extent the protocol is evidence-based, peer-reviewed, and nationally recognized, as required by regulations adopted by the appeals board. If a party offers into evidence a portion of a treatment protocol, any other party may offer into evidence additional portions of the protocol. The party offering a protocol, or portion thereof, into evidence shall either make a printed copy of the full protocol available for review and copying, or shall provide an Internet address at which the entire protocol may be accessed without charge.

(i) The medical treatment guidelines pursuant to section 4604.5.

Labor Code Section 238.71

Collection of Medical Billing Data

SEC. _. Section 238.71 is added to the Labor Code to read:

138.71. (a) The Commission on Health and Safety, in consultation with the Department of Insurance and the administrative director, shall develop an information collection system that shall be jointly administered. The administrative director, in consultation with the Department of Insurance and the commission shall adopt regulations specifying the data elements to be collected by electronic data interchange or otherwise.

(b) The information system shall do the following:
(1) Identify physicians that consistently over treat.
(2) Identify medical providers that consistently over bill.
(3) Identify medical providers engaged in fraudulent activity.
(4) Provide such additional data as the commission, the Insurance Commissioner, and the administrative director shall jointly deem appropriate.

(c) This section shall be operative only until such time as the workers' compensation information system established by Section 138.6 shall be able to provide the information and data described in subdivision (b).

Labor Code Section 4062.5

Time for completion of evaluation; Right to new evaluation

SEC. ___. Section 4062.5 of the Labor Code is amended to read:

4062.5 (a) If a qualified medical evaluator selected by an unrepresented employee from a three-member panel fails to complete the formal medical evaluation within the timeframes established by the administrative director pursuant to paragraph (1) of subdivision (j) of Section 139.2, the employee shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a formal medical evaluation. Neither the employee nor the employer shall have any liability for payment for the formal medical evaluation which was not completed within the required timeframes unless the employee, on a form prescribed by the administrative director, waives his or her right to a new evaluation and elects to accept the original evaluation even though it was not completed within the required timeframes.

(b) If a qualified medical evaluator selected by the medical director fails to complete the disputed medical treatment evaluation within the time-frames established pursuant to subdivision (e) of Section 4616, the employee shall have the right to a new qualified medical evaluator selected by the medical director. Neither the employee nor the employer shall have any liability for payment for the disputed medical treatment evaluation that was not completed within the required timeframes unless the employee, on a form prescribed by the administrative director,

waives his or her right to a new evaluation and elects to accept the original evaluation even though it was not completed within the required timeframes.

Labor Code section 4062.9

Training on Medical Guidelines

SEC. ___. Section 4062.9 of the Labor Code is amended to read:

4062.9 (a) ~~In cases where an additional comprehensive medical evaluation is obtained under Section 4061 or 4062, if the employee has been treated by his or her personal physician, or by his or her personal chiropractor, as defined in Section 4601, who was predesignated prior to the date of injury as provided under Section 4600, the findings of the personal physician or personal chiropractor are presumed to be correct. This presumption is rebuttable and may be controverted by a preponderance of medical opinion indicating a different level of disability. However, the presumption shall not apply where both parties select qualified medical examiners.~~

~~(b) In all cases other than those specified in subdivision (a), regardless~~ Regardless of the date of injury, if the employee has been treated by his or her personal physician, or by his or her personal chiropractor, as defined in Section 4601, and regardless of whether the physician or chiropractor was predesignated prior to the date of injury as provided under Section 4600, no presumption of correctness shall apply to the opinion of any physician or chiropractor on the issue of extent and scope of medical treatment, either prior or subsequent to the issuance of an award, compensability determination, or disability rating.

~~(c)~~ (b) The administrative director shall develop, not later than January 1, 2004, and periodically revise as necessary thereafter, educational materials to be used to provide treating physicians and chiropractors with information and training in basic concepts of workers' compensation, the role of the treating physician, the importance of a treatment plan to speed return to work and norms for disability durations for the 15 most common workplace injuries, the conduct of permanent and stationary evaluations, and report writing.

~~(d)~~ (c) The administrative director shall, directly, by interagency agreement, or, to the extent permitted by state law, by contract, develop not later than January 1, 2005, and periodically revise as necessary thereafter, educational materials and training programs of at least 12 hours in duration for treating physicians and qualified medical evaluators in the use of the guidelines for medical treatment utilization in effect pursuant to section 4604.5.

~~(d)~~ (e)The amendment made to this section by ~~SB 228 of the 2003-04 Regular Session~~ Chapter 639 of the Statutes of 2003 shall not constitute good cause to reopen or rescind, alter, or amend any order, decision, or award of the appeals board.

Labor Code section 4600

Medical Treatment Defined

SEC. ___. Section 4600 of the Labor Code is amended to read:

4600. (a) Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of the injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment. ~~After~~

(b) (1) For purposes of this section "medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury" shall mean all of the following:

(A) The treatment is in accordance with evidence-based medical treatment guidelines generally recognized by the medical community or generally accepted standards of medical practice that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.

(B) The treatment is clinically appropriate, in terms of safety, type, frequency, extent, site, and duration, and considered effective for the patient's injury.

(C) The treatment is not more costly than an alternative service or sequence of services likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the injured worker's injury.

(2) Paragraph (1) shall be applicable to all treatment requested on or after January 1, 2005, including treatment for injuries sustained prior to that date.

(c) After 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area. However, if an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury. If an employee requests a change of physician pursuant to Section 4601, the request may be made at any time after the injury, and the alternative physician, chiropractor, or acupuncturist shall be provided within five days of the request as required by Section 4601. For the purpose of this section, "personal physician" means the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history.

(d) Where at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation judge, the employee submits to examination by a physician, he or she shall be entitled to receive in addition to all other benefits herein provided all reasonable expenses of transportation, meals, and lodging incident to reporting for the

examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination.

(e) Regardless of the date of injury, "reasonable expenses of transportation" includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of the Department of Personnel Administration pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time he or she is given notification of the time and place of the examination.

(f) Where at the request of the employer, the employer's insurer, the administrative director, the appeals board, a workers' compensation judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, he or she shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, "qualified interpreter" means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

Labor Code section 4600.2

Guidelines Limiting Liability of Employer

SEC. _____ Section 4600.2 is amended to read:

4600.2(a) Notwithstanding Section 4600, when a self-insured employer, group of self-insured employers, insurer of an employer, or group of insurers contracts with a pharmacy, group of pharmacies, or pharmacy benefit network to provide medicines and medical supplies required by this article to be provided to injured employees, those injured employees that are subject to the contract shall be provided medicines and medical supplies in the manner prescribed in the contract for as long as medicines or medical supplies are reasonably required to cure or relieve the injured employee from the effects of the injury, subject to the guidelines in effect pursuant to section 4604.5.

(b) Nothing in this section shall affect the ability of employee-selected physicians to continue to prescribe and have the employer provide medicines and medical supplies that the physicians deem reasonably required to cure or relieve the injured employee from the effects of the injury, subject to the guidelines in effect pursuant to section 4604.5.

(c) Each contract described in subdivision (a) shall comply with standards adopted by the administrative director. In adopting those standards, the administrative director shall seek to reduce pharmaceutical costs and may consult any relevant studies or practices in other states. The standards shall provide for access to a pharmacy within a reasonable geographic distance from an injured employee's residence.

Labor Code Section 4603.2

Billing Above Fee Schedule Rate – Pattern or Practice Penalty

SEC. 25. Section 4603.2 of the Labor Code is amended to read:

4603.2. (a) Upon selecting a physician pursuant to Section 4600, the employee or physician shall forthwith notify the employer of the name and address of the physician. The physician shall submit a report to the employer within five working days from the date of the initial examination and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

(b) (1) Except as provided in subdivision (d) of Section 4603.4, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within ~~45~~ 30 working days after receipt of each separate, itemized billing, together with any required reports and any written authorization for services that may have been received by the physician. If the billing or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the billing is contested, denied, or considered incomplete, within 30 working days after receipt of the billing by the employer. A notice that a billing is incomplete shall state all additional information required to make a decision. Any properly documented amount not paid within the ~~45-working-day~~ 30-working-day period shall be increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill, unless the employer does both of the following:

(A) Pays the uncontested amount within the ~~45-working-day~~ 30-working-day period.

(B) Advises, in the manner prescribed by the administrative director, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of a bill ~~which~~ that includes charges from a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the bill shall satisfy the requirements of this paragraph.

If an employer contests all or part of a billing, ~~any~~ the amount determined payable by the appeals board shall carry interest from the date the amount was due until it is paid. If any contested amount is determined payable by the appeals board, the defendant shall be ordered to reimburse the ~~provider~~ lienholder for any filing fees paid pursuant to Section 4903.05.

An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

(2) Notwithstanding paragraph (1), if the employer is a governmental entity, payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made within 60 working days after receipt of each separate, itemized billing, together with any required reports and any written authorization for services that may have been received by the physician.

(c) Any interest or increase in compensation paid by an insurer pursuant to this section shall be treated in the same manner as an increase in compensation under subdivision (d) of Section 4650 for the purposes of any classification of risks and premium rates, and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of a billing submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that billing by the physician or medical provider. When an individual or entity conducting a bill review determines that additional information or documentation is necessary to review the billing, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) An individual or entity reviewing a bill submitted by a physician or medical provider shall not alter the procedure codes billed or recommend reduction of the amount of the bill unless the documentation submitted by the physician or medical provider with the bill has been reviewed by that individual or entity. If the reviewer does not recommend payment as billed by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or amount billed and the specific deficiency in the billing or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

(3) The appeals board shall have jurisdiction over disputes arising out of this subdivision pursuant to Section 5304.

(e) (1) Physicians and medical providers shall bill at or below the maximum fees provided in the official medical fee schedule unless the employer or insurer has agreed to a greater fee.

(2)The administrative director may assess an administrative penalty, not to exceed five thousand dollars ($5,000), against any physician or medical provider that bills above the maximum fees provided in the official medical fee schedule with sufficient frequency to indicate a general practice.

(3) The administrative director may order a physician or medical provider that bills above the maximum fees provided in the official medical fee schedule with sufficient frequency to indicate a general practice to refund to any payer the amount received in excess of the maximum fees provided in the official medical fee schedule, together with interest at the same rate as judgments in civil actions from the date of payment by the payer.

(4) If a physician or medical provider continues to bill above the maximum fees provided in the official medical fee schedule with sufficient frequency to indicate a general practice after a final order of the administrative director has been issued against that physician or provider under paragraph (2) or (3), the administrative director may order that the physician or medical provider is disqualified from receiving any payment under this division for any future goods or services rendered by that physician or provider.

(5) (A) Orders of the administrative director under paragraph (2), (3), or (4) may be issued in one proceeding or in separate proceedings, but if in separate proceedings, the same instances of overbilling shall not be the grounds for multiple orders. Orders of the administrative director under paragraph (2), (3), (4) shall be initiated by a notice of intention served by the administrative director upon the physician or medical provider. The notice of intention shall be served no later than two years after the last instance of overbilling, based on the date of billing or rebilling and not on the date of the medical service, that is stated in the notice of intention. The notice of intention shall include a written statement of the alleged instances of overbilling in order that the respondent may prepare a defense. The physician or medical provider may serve a written objection on the administrative director within 20 days of service of the notice of intention. The objection shall contain a specific statement of the defenses to the proposed order, not merely a general denial, and may include documentary evidence. Any defense shall be conclusively deemed to be waived unless the defense is specifically stated by written objection within 20 days, or within 60 additional days if an extension is requested within 20 days of the service of the notice of intention.

(B) The administrative director may conduct any hearing as the administrative director deems appropriate prior to issuing a final order. Any physician or medical provider aggrieved by the final order of the administrative director may appeal the order of the administrative director within 20 days of service of the final order by filing an appeal at the district office of the appeals board for the county in which the physician or medical provider rendered the largest number of the services specified in the notice of intention and serving a copy on the administrative director. Except as otherwise specified in this subdivision, the proceedings for appeal of the order of the administrative director shall be conducted in accordance with Part 4 (commencing with Section 5300).

(6) The administrative director shall adopt rules and regulations as may be necessary to carry out the provisions of this section and may include definitions of "physician" and "medical provider" in order to prevent any person from circumventing this section by using tactics such as changing business names or utilizing different partnerships or corporate entities.

Labor Code sections 4604

Medical Treatment Subject to Medical Evaluation Before Appeal to WCAB

SEC. ___. Section 4604 of the Labor Code is amended to read:

4604. ~~Controversies between employer and employee arising under this chapter shall be determined by the appeals board, upon the request of either party~~. Controversies, other than those subject to the medical evaluation process set forth in Sections 4615 and 4616, arising between employer and employee under this chapter shall be determined by the appeals board upon the request of either party. With respect to disputes subject to the medical evaluation process, the jurisdiction of the appeals board shall be limited in accordance with Section 4616.

Labor Code Section 4610

Utilization Review

SEC. ___. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny~~, based in whole or in part on medical necessity to cure and relieve~~, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment ~~services~~ pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services. An employer may satisfy this requirement by contracting with a health care organization pursuant to Section 4600.5 for health care services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions ~~based on the medical necessity to cure and relieve of proposed~~ regarding medical treatment ~~services~~ are consistent with the ~~schedule proposed~~ guidelines for medical treatment utilization ~~adopted pursuant to Section 5307.27~~. ~~Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.~~ in effect pursuant to section 4604.5 and subdivision (b) of section 4600. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment ~~for reasons of medical necessity to cure and relieve~~.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the ~~schedule~~ guidelines for medical treatment utilization ~~adopted pursuant to Section 5307.27~~. ~~Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational~~

~~and Environmental Medicine Occupational Medical Practice Guidelines.~~ in effect pursuant to section 4604.5 and subdivision (b) of section 4600.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements must be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee' s condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4062. ~~If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062.~~

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether

or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4062~~, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of Section 4062~~. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment ~~service~~ approved. Responses regarding decisions to modify, delay, or deny medical treatment ~~services~~ requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions ~~regarding medical necessity~~. Every employer response that delays, denies or modifies the physician's request for treatment shall include a one-page form request for the appointment of a qualified medical evaluator selected by the medical director to determine the dispute in accordance with section 4615 and a stamped envelope addressed to the medical director.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested~~, because the employer requires consultation by an expert reviewer,~~ or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for ~~health care services~~ medical treatment.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

Labor Code 4615

Disputed Medical Treatment

SEC. ___. Section 4615 is added to the Labor Code, to read:

4615. (a) For the purposes of this section, "disputed medical treatment" means any medical treatment, as defined by Section 4600, that has been denied, modified, or delayed by a decision of the employer, or any entity with which an employer contracts.

(b) For services requested by a physician, as defined by Section 3209.3, on or after January 1, 2005, disputed medical treatment shall be resolved by submitting the dispute to a qualified medical evaluator or an agreed medical evaluator for review, if both of the following conditions are met:

(1) The injury for which medical treatment has been requested is an accepted injury;

(2) If an agreed medical evaluator has not been selected, the employee has timely requested medical evaluation by filing with the medical director appointed pursuant to section 122 the one-page form provided pursuant to subdivision (g) of Section 4610. Timely requests are forms postmarked within 30 days of the receipt of the employer response.

(c) If the employee is represented by an attorney, the parties may seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed medical treatment issue as an agreed medical evaluator. If the parties had previously agreed on an agreed medical evaluator to resolve any other issues, the parties shall use the same agreed medical evaluator, to the extent possible, to resolve the current disputed medical treatment issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator and the employee may only request a qualified medical evaluator from the medical director within the time limits set forth in subdivision (b).

(d) The medical director shall, within 10 days of receipt of the request for medical evaluation, select a qualified medical evaluator who is competent to evaluate the specific clinical issues involved in the medical treatment services disputed and immediately notify the employee and the employer in writing as to the name, mailing address, and telephone number of the qualified medical evaluator appointed and send notice to the qualified medical evaluator as to his or her selection.

(e) The employer shall provide to the agreed medical evaluator or qualified medical evaluator designated by the medical director a copy of all documents necessary to conduct the medical evaluation, pursuant to regulations promulgated by the administrative director, within 10 business days of agreement on the agreed medical evaluator or receipt of the notice of the selected qualified medical evaluator**.** The employer shall concurrently provide a copy of medical records required by this paragraph, if not previously provided, and an annotated list and copies of all other documents submitted to the qualified medical evaluator to the employee, or his or her representative.

(f) The employer shall immediately arrange with the office of the agreed medical evaluator or qualified medical evaluator selected by the medical director for a medical examination date and time and send notice of the date, time and place of the examination to the employee with applicable mileage reimbursement.

(g)The confidentiality of any employee's medical information shall be maintained by the division and the agreed or qualified medical evaluator as required by applicable state and federal laws. The division and the agreed or qualified medical evaluator shall maintain the confidentiality of any information found by the administrative director to be the proprietary information of the employer. However, the employee may waive confidentiality by signing a release, particularly for the purpose of providing the employer with information necessary to provide modified work.

(h) The employer shall be liable for those services that are determined reasonably required to cure or relieve by a medical evaluation pursuant to Section 4616 and any additional medical treatment approved by the appeals board subject to the guidelines in effect pursuant to Section 4604.5 and subdivision (b) of Section 4600 following the medical evaluation.

Labor Code section 4616

Medical Evaluations

SEC. ___. Section 4616 of the Labor Code is added to read:

4616. (a) For purposes of this section "medical evaluator" shall mean either an agreed medical evaluator or a qualified medical evaluator selected by the medical director.

(b) When an agreed medical evaluator is not selected pursuant to section 4615, medical evaluations shall be conducted by qualified medical evaluators selected by the medical director appointed pursuant to section 122 on a random basis within a specialty appropriate for the clinical issues to be evaluated from the list of qualified medical evaluators as defined in Section 139.2.

(c) The medical evaluator shall conduct the evaluation of the disputed medical treatment in accordance with any regulations of the administrative director. The evaluation shall be limited to the reasonableness of the disputed medical treatment, in light of the guidelines in effect pursuant to Section 4604.5 and subdivision (b) of Section 4600, and shall not include any consideration of compensability or other legal issues. The medical evaluator shall first review all pertinent medical records and documents submitted pursuant to subdivision (e) of Section 4615 and any other information as authorized by the administrative director. If the medical evaluator concludes that the disputed medical treatment is reasonable and issues a medical report approving it, no physical examination of the employee shall be required and the appointment made by the employer shall be canceled by the medical evaluator. If the medical evaluator concludes after the record review that the disputed medical treatment appears unreasonable, a physical examination of the employee shall be required.

(d) If the medical evaluator requests any additional information from any of the parties, a copy of the request and the response shall be provided to all of the parties.

(e) The medical evaluator shall complete the review of records and physical examination, if necessary, and make a written determination using layperson's terms to the maximum extent practicable, within 90 days of the receipt of the documents provided by the employer as set forth in subdivision (e) of section 4615, or within less time as prescribed by the administrative director, for a document review alone. The administrative director shall adopt regulations specifying a standardized format for, and minimum required elements of, written determinations made pursuant to this section.

(f) The medical evaluator's analyses and determinations shall state whether the disputed medical treatment is consistent with the guidelines in effect pursuant to Section 4604.5 and subdivision (b) of Section 4600. Each analysis shall state the employee's medical condition, the relevant documents in the record, and the relevant findings to support the determination, including, in a case in which a physical examination has taken place, why the documents led the medical evaluator to the conclusion the treatment was unreasonable and what the physical examination revealed that either confirmed or contradicted the initial conclusion.

(g) The medical evaluator shall promptly serve the administrative director, the employer, the employee, and the employee's treating physician with the analyses and determination. The determination shall be accompanied by a notice, in a form determined by the administrative director, informing the employee of his or her appeal rights.

(h) Upon receipt of a determination by the medical evaluator that the disputed medical treatment is reasonably required to cure or relieve the employee's injury, the employer shall authorize the disputed medical treatment.

(i) An employer or other entity shall not engage in any conduct that unreasonably delays the medical evaluation process or implementation of the determination of the medical evaluator, including, but not limited to, appeal of determinations to the appeals board.

(j) If the disputed medical treatment is disapproved by the medical evaluator, the employee may appeal to the appeals board by filing a declaration of readiness to proceed. However, the determination of the medical evaluator shall be presumed correct. This presumption is rebuttable and may be controverted by a preponderance of the medical evidence establishing that the treatment is medically necessary in accordance with the guidelines in effect pursuant to Section 4604.5 or subdivision (b) of section 4600.

(k) The admissible evidence before the appeals board shall be limited to reports and records of the primary treating physician and the requesting physician if different than the treating physician, the reports and records submitted for medical evaluation, the determination and analyses of the physician performing the medical evaluation, the records of the employer's utilization review, and the depositions and live testimony and cross-examination of the employee, the requesting physician, and the medical evaluator. As to the medical treatment in dispute, no additional medical examinations or evaluations shall be compensated and no written or testimonial evidence on these additional examinations or evaluations shall be admissible before the appeals board.

Labor Code section 4617

Medical Evaluation Costs

SEC. ___. Section 4617 is added to the Labor Code, to read:

4617. (a) The cost of the medical evaluation specified in Section 4616 shall be borne by the employer.

(b) The administrative director shall establish a reasonable reimbursement schedule for payment of medical evaluators, including administrative costs.

Labor Code section 5502

Time for Hearing; Priority Calendar; Reports; Mandatory Settlement Conference

SEC. ___. Section 5502 of the Labor Code is amended to read:

5502. (a) Except as provided in subdivisions (b) and (d), the hearing shall be held not less than 10 days, and not more than 60 days, after the date a declaration of readiness to proceed, on a form prescribed by the court administrator, is filed. If a claim form has been filed for an injury occurring on or after January 1, 1990, and before January 1, 1994, an application for adjudication shall accompany the declaration of readiness to proceed.

(b) The court administrator shall establish a priority calendar for issues requiring an expedited hearing and decision. A hearing shall be held and a determination as to the rights of the parties shall be made and filed within 30 days after the declaration of readiness to proceed is filed if the issues in dispute are any of the following:

(1) The employee's entitlement to medical treatment pursuant to Section 4600, or the extent and scope of medical treatment following medical evaluation pursuant to Section 4616.

(2) The employee's entitlement to, or the amount of, temporary disability indemnity payments.

(3) The employee's entitlement to vocational rehabilitation services, or the termination of an employer's liability to provide these services to an employee.

(4) Liability of an employer for an injury after liability has been rejected pursuant to Section 5402.

(5) The employee's entitlement to compensation from one or more responsible employers when two or more employers dispute liability as among themselves.

(6) Any other issues requiring an expedited hearing and determination as prescribed in rules and regulations of the administrative director.

(c) The court administrator shall establish a priority conference calendar for cases in which the employee is represented by an attorney and the issues in dispute are employment or injury arising out of employment or in the course of employment. The conference shall be conducted by a workers' compensation administrative law judge within 30 days after the declaration of readiness to proceed. If the dispute cannot be resolved at the conference, a trial shall be set as expeditiously as possible, unless good cause is shown why discovery is not complete, in which case status conferences shall be held at regular intervals. The case shall be set for trial when discovery is complete, or when the workers' compensation administrative law judge determines that the parties have had sufficient time in which to complete reasonable discovery. A determination as to the rights of the parties shall be made and filed within 30 days after the trial.

(d) The court administrator shall report quarterly to the Governor and to the Legislature concerning the frequency and types of issues which are not heard and decided within the period prescribed in this section and the reasons therefore.

(e) (1) In all cases, a mandatory settlement conference shall be conducted not less than 10 days, and not more than 30 days, after the filing of a declaration of readiness to proceed. If the dispute is not resolved, the regular hearing shall be held within 75 days after the declaration of readiness to proceed is filed.

(2) The settlement conference shall be conducted by a workers' compensation administrative law judge or by a referee who is eligible to be a workers' compensation administrative law judge or eligible to be an arbitrator under Section 5270.5. At the mandatory settlement conference, the referee or workers' compensation administrative law judge shall have the authority to resolve the dispute, including the authority to approve a compromise and release or issue a stipulated finding and award, and if the dispute cannot be resolved, to frame the issues and stipulations for trial. The appeals board shall adopt any regulations needed to implement this subdivision. The presiding workers' compensation administrative law judge shall supervise settlement conference referees in the performance of their judicial functions under this subdivision.

(3) If the claim is not resolved at the mandatory settlement conference, the parties shall file a pretrial conference statement noting the specific issues in dispute, each party's proposed permanent disability rating, and listing the exhibits, and disclosing witnesses. Discovery shall close on the date of the mandatory settlement conference. Evidence not disclosed or obtained thereafter shall not be admissible unless the proponent of the evidence can demonstrate that it was not available or could not have been discovered by the exercise of due diligence prior to the settlement conference.

(f) In cases involving the Director of ~~the Department of~~ Industrial Relations in his or her capacity as administrator of the Uninsured Employers Fund, this section shall not apply unless proof of service, as specified in paragraph (1) of subdivision (d) of Section 3716 has been filed with the appeals board and provided to the Director of Industrial Relations, valid jurisdiction has been established over the employer, and the fund has been joined.

(g) Except as provided in subdivision (a) and in Section 4065, ~~the provisions of~~ this section shall apply irrespective of the date of injury.

SEC. ___. Section 48 of Chapter 639 of the Statues of 2003 is repealed.

Sec. 48. ~~The Commission on Health and Safety and Workers' Compensation shall conduct a study of the spinal surgery second opinion procedure established in subdivision (b) of Section 4062 of the Labor Code. The study shall be completed by June 30, 2006. The commion shall issue a report concerning the findings of the study and recommendations for further legislation.~~

Labor Code Section 5307.1

Physician Fees Indexed to Medicare

SEC. ___. Section 5307.1 of the Labor Code is amended to read:

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services other than physician services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivision (j) and physician services as provided in subdivisions (k) and (l), maximum reasonable fees shall be ~~120~~ 115 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision ~~(e)~~ (g), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed ~~120~~ 115 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision ~~(e)~~ (g). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed ~~120~~ 115 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, may not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish

maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item, provided, however, that the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or, with regard to pharmacy services and drugs, for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other provision of law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, provided that both of the following conditions are met:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year.

(B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11370) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the division of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

(A) "Medicare Economic Index" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) "Hospital market basket" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

(C) "Hospital market basket for excluded hospitals" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(h) Nothing in this section shall prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components may not become part of the official medical fee schedule until January 1, 2005:
(1) Inpatient skilled nursing facility care.
(2) Home health agency services.
(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.
(4) Outpatient renal dialysis services.

(k) Notwithstanding subdivision (a), for the calendar years 2004 and 2005, the existing official medical fee schedule rates for physician services shall remain in effect, but these rates shall be reduced by 5 percent. The administrative director may reduce fees of individual procedures by different amounts, but in no event shall the administrative director reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure.

(l) Notwithstanding subdivision (a), the administrative director, commencing January 1, 2006, shall ~~have the authority, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services. If the administrative director fails to adopt an official medical fee schedule for physician services by January 1, 2006, the existing official medical fee schedule rates for physician services shall remain in effect until a new schedule is adopted or the existing schedule is revised~~ adopt, after public hearing, and review and revise periodically as appropriate, an official medical fee schedule for physician services in accordance with the fee-related structure and rules of the relevant Medicare payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. However, the conversion factor applicable to physician and other practitioner services shall not be lower than the Medicare conversion factor in effect for those services on December 31, 2003.

ANTI-FRAUD MEASURES

Problem: The current culture of California's workers' compensation system is one where abuse and fraud are widespread and serve as a cost driver in the system. This culture must change. The high premiums, low benefits, and overall inequity of the current workers' compensation system contribute to an environment that is highly vulnerable to fraud. Workers' compensation fraud includes abusive and fraudulent provider billing practices (up-coding, unbundling, prescription billing, durable equipment, and services not rendered), medical-legal mills, and applicant and insider fraud. Numerous factors exacerbate and perpetuate workers' compensation fraud, including personal and business economic hardship, public acceptance of insurance fraud, and inadequate resources (manpower and funding) to investigate insurance fraud cases. Some insurance companies have also been derelict in their responsibility to fight fraud. The lack of uniform methodology and standards for assessing and reporting suspected fraud is a contributing factor.

Solution: The California Department of Insurance (CDI) is restructuring its fraud and investigative units to improve coordination efforts and to prioritize workers' compensation cases. CDI is also improving its working relationship with district attorneys and other state, federal, and local law enforcement agencies with an emphasis on information sharing. As part of these anti-fraud efforts, CDI supports immunity for individuals reporting suspected fraud. CDI also proposes making uninsured employers subject to felony charges.

Labor Code section 3700.5.

Uninsured Employer Fraud is Punishable by Jail or Prison (Wobbler)

SEC.___. Labor Code Section 3700.5 is amended to read:

3700.5 (a) The failure to secure the payment of compensation as required by this article by one who new, or because of his or her knowledge or experience should be reasonably expected to have known, of the obligation to secure the payment of compensation, is a misdemeanor punishable by imprisonment in the county jail for up to one year, or by a fine of up to ~~ten thousand dollars ($10,000)~~ double the amount of premium, as determined by the court that would otherwise have been due to secure the payment of a compensation during the time compensation was not secured, but not less than $10,000, or by both that imprisonment and fine.
(b) A second or subsequent conviction shall be punishable by imprisonment in county jail for one year, or in the state prison, for two, three, or five years, or by a fine not to exceed triple the amount of premium as determined by the court, that would otherwise have been due to secure the payment of compensation during the time payment was not secured, but not less than $50,000 , or by both that imprisonment and fine.
(c) Any person convicted under this section may be charged the costs of investigation at the discretion of the court.

Labor Code Section 3711

Powers to CDI and DA for Fighting Fraud

SEC.___. Labor Code Section 3711 is amended to read:

The director, an investigator for the Department of Insurance Fraud Bureau or its successor, or a district attorney investigator assigned to investigate a workers' compensation fraud, may at any time, require any employer to furnish a written statement showing the name of his or her insurer or the manner in which the employer has complied with the provisions of Section 3700. Failure of the employer for a period of 10 days to furnish the written statement is prima facie evidence that he or she has failed or neglected in respect to the matters so required. The 10-day period shall not be construed to allow an uninsured employer, so found by the director, any extension of time from the application of the provisions of Section 3710.1. An insured employer who fails to respond to an inquiry respecting his or her status as to his or her workers' compensation security shall be assessed and required to pay a penalty of five hundred dollars ($500) to the director for deposit in the State Treasury to the credit of the Uninsured Employers Fund. In any prosecution under this article, the burden of proof is upon the defendant to show that he or she has secured the payment of compensation in one of the two ways set forth in Section 3700.

Labor Code Section 3823

Immunity Clause for Provider Fraud

SEC.___. Labor Code Section 3823 is amended to read:

3823. (a) The administrative director shall, in coordination with the Bureau of Fraudulent Claims of the Department of Insurance, the Medi-Cal Fraud Task Force, and the Bureau of Medi-Cal Fraud and Elder Abuse of the Department of Justice, adopt protocols, to the extent that these protocols are applicable to achieve the purpose of subdivision (b), similar to those adopted by the Department of Insurance concerning medical billing and provider fraud.

(b) Any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that believes that a fraudulent claim has been made by any person or entity providing medical care, as described in Section 4600, shall report the apparent fraudulent claim in the manner prescribed by subdivision (a).

(c) No person or entity set forth in subdivision (b) who furnishes information, written or oral, pursuant to this section, and no authorized governmental agency or its employees who furnishes or receives information, written or oral, pursuant to this section or who assists in any investigation of a suspected violation of Section 3215 or 3219 of this code, or of Section 1871.1, 1871.4, 11760, or 11880, of the Insurance Code, or of Section 549 of the Penal Code, conducted by an authorized governmental agency, shall be subject to any civil liability in a cause of action on the basis of conduct described in this section where the person or entity or authorized governmental agency acts in good faith, without malice, and reasonably believes that the action taken was warranted by the then-known facts, obtained through reasonable efforts. This section does not abrogate or diminish the common or statutory privileges and immunities of any person or entity in subdivision (b), or of any authorized governmental agency or its employees.

Insurance Code Section 1871.4

Recovering Costs of Fraud Investigations

SEC.___. Insurance Code Section 1871.4 is amended to read:

1871.4 (a) It is unlawful to do any of the following:
(1) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.
(2) Present or cause to be presented any knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.
(3) Knowingly assist, abet, conspire with, or solicit any person in an unlawful act under this section.
(4) Make or cause to be made any knowingly false or fraudulent statements with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.
For the purposes of this subdivision, "statement" includes, but is not limited to, any notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-ray, test results, medical-legal expense as defined in Section 4620 of the Labor Code, other evidence of loss, injury, or expense, or payment.
(5) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.
(6) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of discouraging an employer from claiming any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.
(b) Every person who violates subdivision (a) shall be punished by imprisonment in county jail for one year, or in the state prison, for two, three, or five years, or by a fine not exceeding one hundred fifty thousand dollars ($150,000) or double the value of the fraud, whichever is greater, or by both imprisonment and fine. Restitution shall be ordered, including restitution for any medical evaluation or treatment services obtained or provided. The court shall determine the amount of restitution and the person or persons to whom the restitution shall be paid. <u>Any person convicted under this section may be charged the costs of investigation at the discretion of the court.</u>
(c) Any person who violates subdivision (a) and who has a prior felony conviction of that subdivision, of former Section 556, of former Section 1871.1, or of Section 548 or 550 of the Penal Code, shall receive a two-year enhancement for each prior conviction in addition to the sentence provided in subdivision (b).
The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue ofguilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

(d) This section shall not be construed to preclude the applicability of any other provision of criminal law that applies or may apply to any transaction.

Penal Code Section 1524

Search Warrants for WC Insurance Fraud Evidence

SEC.___. Penal Code Section 1524 is amended to read:

1524. (a) A search warrant may be issued upon any of the following grounds:
(1) When the property was stolen or embezzled.
(2) When the property or things were used as the means of committing a felony.
(3) When the property or things are in the possession of any person with the intent to use them as a means of committing a public offense, or in the possession of another to whom he or she may have delivered them for the purpose of concealing them or preventing their being discovered.
(4) When the property or things to be seized consists of any item or constitute any evidence that tends to show a felony has been committed, or tends to show that a particular person has committed a felony.
(5) When the property or things to be seized consists of evidence that tends to show that sexual exploitation of a child, in violation of Section 311.3, or possession of matter depicting sexual conduct of a person under the age of 18 years, in violation of Section 311.11, has occurred or is occurring.
(6) When there is a warrant to arrest a person.
(7) When a provider of electronic communication service or remote computing service has records or evidence, as specified in Section 1524.3, showing that property was stolen or embezzled constituting a misdemeanor, or that property or things are in the possession of any person with the intent to use them as a means of committing a misdemeanor public offense, or in the possession of another to whom he or she may have delivered them for the purpose of concealing them or preventing their discovery.
(8) <u>When the property or things to be seized consist of any item or constitute any evidence that tends to show a violation of Section 3700.5 of the Labor Code, or tends to show that a particular person has violated Section 3700.5 of the Labor Code.</u>

STATE COMPENSATION INSURANCE FUND

Problem: Elimination of the minimum rate law in 1995 led to a vicious cycle of underpricing workers' compensation premiums. Since that time, more than two-dozen workers' compensation insurance companies have been placed in regulatory conservation, liquidation, or supervision. As these companies failed and competition dwindled, State Compensation Insurance Fund, the insurer of last resort, picked up the slack, growing from 20% of California's workers' compensation market in 2001 to well over 50% of the market today. The impact of this rapid growth has placed enormous strain on the organizational structure and financial position of State Fund. To correct these problems, State Fund must undertake a series of difficult, but necessary adjustments to build up its financial strength.

Solution: Current law requires that all five voting SCIF Board Members must be SCIF policyholders 12 months prior to being appointed to the SCIF Board and during their entire tenure on the Board. We support adding two additional voting SCIF Board Members who are exempted from the SCIF policyholder requirement. This freedom and flexibility would allow recruitment of specialized expertise and fresh perspectives for SCIF oversight. Clarify that the Insurance Commissioner's existing authority over State Fund is the same as over any other workers' compensation insurance company.

Insurance Code Section 11770

Changes to SCIF Board of Directors

SEC. ___. Section 11770 of the Insurance Code, is amended to read:

11770. The State Compensation Insurance Fund is continued in existence, to be administered by its board of directors for the purpose of transacting workers' compensation insurance, and insurance against the expense of defending any suit for serious and willful misconduct, against an employer or his or her agent, and insurance to employees and other persons of the compensation fixed by the workers' compensation laws for employees and their dependents. Any appropriation made therefrom or thereto before the effective date of this code shall continue to be available for the purposes for which it was made.

The board of directors of the State Compensation Insurance Fund is composed of ~~five~~ seven members, one of whom shall be from organized labor, appointed by the Governor. The Governor shall appoint the chairperson who shall serve at the pleasure of the Governor. The Director of Industrial Relations, the Speaker of the Assembly, and the President pro Tempore of the Senate, or their designees, shall be ex officio, nonvoting members of the board, and shall not be counted as members of the board for quorum purposes or any other purpose.

The term of office of the members of the board, other than that of the director, the Speaker of the Assembly, and the President pro Tempore of the Senate, shall be five years and they shall hold office until the appointment and qualification of their successors. The term of office of the first additional member appointed pursuant to amendment of this section effective January 1, 1990, shall expire on January 15, 1995. Commencing January 15, 1991, the terms of office of other

members shall be extended to five years as each four-year term expires, so that one member's term of office expires January 15 of each year. Each member shall receive his or her actual and necessary traveling expenses incurred in the performance of his or her duty as a member and, with the exception of the ex officio members, one hundred dollars ($100) for each day of his or her actual attendance at meetings of the board. In order to qualify for membership, five of the members on the board, ~~each member~~ other than the ex officio members shall each have been a policyholder or the employee or member of a policyholder in the State Compensation Insurance Fund for one year immediately preceding the appointment, and must continue in this status during the period of his or her membership. Any member who is not a policyholder or an employee or member of a policyholder in the fund shall not have been an employee, officer, or member of the board of directors of an insurance company during the 12 months prior to the member's appointment to the board, nor have a controlling interest in an insurance company.

Insurance Code Section 11778

SCIF Regulated Like All Insurance Companies

SEC. ___. Section 11778 of the Insurance Code, is amended to read:

11778. The fund may transact workers' compensation insurance required or authorized by law of this state to the same extent as any other insurer. The fund shall be subject to the authority of the Insurance Commissioner to the same extent as any other insurer transacting workers' compensation insurance.

PENALTIES

Problem: Penalties imposed on insurers for late and inadequate payment of claims should have a reasonable relationship to the violation. The current penalty structure is irrational, allowing penalties to be assessed against the species of benefits paid, both past and future, for the entire claim, rather than the specific amount of payment that was either delayed or refused. Consequently, in a case where $200,000 in medical benefits was paid, a late $10 payment on reimbursement for a prescription to an injured worker can result in a 10% penalty or $20,000. The current structure provides strong incentives to allege penalties in order to gain larger settlements resulting in inequitable penalties and unnecessary litigation. The 2003 reforms exempted CIGA from paying 5814 penalties on inherited claims, but the 5814 penalty structure was not addressed.

Solution: Require injured workers and their attorneys to timely and specifically report when they believe employers have unreasonably delayed or refused to pay benefits. Allow for disputes on unreasonably refused or delayed benefits to be resolved without litigation and payment of an immediate, no-fault 10% penalty based upon the amount that was refused or delayed. If the matter is disputed further, allow for the assessment of a larger 25% penalty on the amount in dispute or $500, whichever is greater. This would help create a more responsive and rational penalty structure that effectively deters the specific negative conduct of the insurer or employer. It would also significantly diminish the opportunity to allege unwarranted penalties and reduce unnecessary litigation.

Labor Code section 5814

Penalties

SEC.___. Section 5814 of the Labor Code is repealed

SEC.___. Section 5814 is added to the Labor Code, to read:

5814. (a) When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the amount of the payment unreasonably delayed or refused shall be increased to 25 percent or five hundred dollars ($500), whichever is greater, in addition to any other self-imposed increases or penalties due under this subdivision. The question of delay and reasonableness of the cause therefor shall be determined by the appeals board in accordance with the facts.

(b) As a precondition to a claim for penalties under this section, the employee shall give written notice to the employer of the claimed unreasonable delay or refusal of payment of compensation. If, within 20 days from the date of service of this notice, the employer pays a self-imposed increase of 10 percent of the amount of payment delayed or refused or five hundred dollars ($500), whichever is greater, in addition to any other self-imposed increases or penalties due under this division, there shall be no further penalty allowed for the delayed or refused payment. If the employer disputes whether the delay or refusal is unreasonable, and the workers' compensation administrative law judge determines that the delay or refusal violates this section,

the workers' compensation administrative law judge shall award the penalty prescribed in subdivision (a). In determining whether the delay or refusal is unreasonable, the workers' compensation administrative law judge shall consider only the specific facts resulting in the delay or refusal of the specific payment that is the subject of the request for penalties.

(c) The appeals board shall have no jurisdiction to hear a claim for penalties under subdivision (a), unless the employee files a claim for a penalty within one year from the date of the alleged unreasonable delay or refusal to pay benefits. Upon the approval of a compromise and release by the appeals board, it shall be conclusively presumed that any existing or potential penalties have been resolved, unless expressly excluded by the terms of the compromise and release.

(d) Nothing in this section shall be construed to create a civil cause of action.

SEC.___. *Section 5814.5 of the Labor Code is repealed.*

RETURN TO WORK

Problem: The overall complexity of the workers' compensation system leads to miscommunication, misinformation and frustration for injured workers and employers. Furthermore, the current system often provides clearer incentives for injured workers to claim disability than to return to work quickly. The lack of communication and misguided incentives contribute to slower medical treatment, longer disability, and increased litigation.

Solution: The best outcome for an injured worker is to get them back to work as quickly as possible. It is the employers' responsibility to ensure this happens. We must restructure the system so that injured workers, employers and all other participants in the system have the proper incentives to return injured workers to work as quickly as possible. Benefit systems must be structured so that injured workers want to return to work and employers want to accept injured workers back, even in a modified capacity, as quickly as possible. Doctors must be appropriately compensated for the time to evaluate return to work. More coordination, collaboration, and integrated communication between doctors, injured workers, and employers focused on getting the injured worker back to work is imperative. HCOs, ombudsman, nurse case managers, and other similar programs all move the system in this direction. Changing incentives and improving communication will reduce time off work, permanent disability costs, and litigation costs.

SEC._____. Labor Code Sections 139.48 and 139.49 are hereby repealed.

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SEC._____. The Legislature finds and declares that an early return to work is in the interest of both workers and employers. Because meaningful transitional, modified or light duty work is often difficult to identify within a workplace, the Legislature further finds and declares that insurers should collaborate with employers as soon as a worker is injured to describe useful transitional, modified or light duty work that can be offered for a limited period of time.

Labor Code Section 139.48 – Return to Work Incentives

SEC. _____. Section 139.48 of the Labor Code is added to the Labor Code to read:

139.48 (a) In order to facilitate an early return to work, all employers eligible for experience rating shall and all other employers may compose a description of the physical requirements of each job, as well as descriptions of the physical requirements of any transitional, modified or light duty work that may be available for a limited period of time. When such descriptions are available, the employer shall promptly present these descriptions to all treating physicians and the worker.

(b) The administrative director shall develop a form upon which treating physicians shall indicate a worker's activity restriction(s) as soon as a worker is able to return to modified work, transitional work or light duty. The form shall include a release to be signed by the worker, allowing the information to be shared with the employer. The form shall also provide a space

for the treating physician to justify the restriction(s), referencing the guidelines adopted pursuant to Labor Code section 4604.5 and any disability duration norms or guidelines that may be adopted by the administrative director.
(c) The administrative director shall also develop a rate of pay for completing the return to work form. Compensation shall be payable for completing a form on which the treating doctor states that the worker is able to perform any modified work, transitional work or light duty, as well as a release for return to regular work.

Labor Code Section 139.49 - Modified Work

SEC. _____. Section 139.49 of the Labor Code is added to the Labor Code to read:

Temporary total disability benefits shall continue until whichever of the following events first occurs:

(a) The worker returns to regular or modified employment;

(b) The attending physician advises the worker and documents in writing that the worker is released to return to regular employment;

(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. However, an offer of modified employment may be refused by the worker without the termination of temporary total disability benefits if the offer:

(A) Requires a commute that is beyond the physical capacity of the worker according to the worker's attending physician;

(B) Is at a work site more than 50 miles one way from where the worker was injured unless the site is less than 50 miles from the worker's residence or the intent of the parties at the time of hire or as established by the pattern of employment prior to the injury was that the employer had multiple or mobile work sites and the worker could be assigned to any such site;

(C) Is not with the employer at injury;

(D) Is not at a work site of the employer at injury;

(E) Is not consistent with the existing written shift change policy or is not consistent with common practice of the employer at injury or aggravation; or

(F) Is not consistent with an existing shift change provision of an applicable collective bargaining agreement; or

(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under provisions of this chapter.

Labor Code section 139.49.1 – Worksite Modification

SEC. _____. Section 139.49.1 of the Labor Code is added to the Labor Code to read:

(a) Worksite Modification means altering a worksite in California by purchasing, modifying, or supplementing equipment, or changing the work process, to enable a worker to work within the limitations imposed by compensable injuries or occupational diseases.

(b) A modification may include purchase or rental of tools, equipment, fixtures, or furnishings to modify a worksite as well as a structural modification in a worksite.

(c) The provision of the following Worksite Modification items or similar items by themselves do not constitute a reimbursable modification:
(1) Anti-fatigue mat;
(2) Slant board;
(3) Anti-vibration wrap for tools;
(4) Special pen or pencil;
(5) Footrest; or
(6) Wristrest.

(d) Modification equipment shall be the property of the employer unless the modification equipment is both unique to the worker and easily transferable, in which case it shall be the property of the worker. Neither the worker nor the employer shall dispose of the property provided for the modification or reassign it to another worker while the worker is employed in work for which the modification is needed.

(e) A Worksite Modification may be requested by a worker and must be agreed to by the employer based upon a report of the primary treating physician describing the need and purpose for the worksite modification, and the costs shall be reimbursed as follows:
(1) A Worksite Modification Agreement shall be completed, dated and signed by the worker, primary treating physician, and employer and sent to the insurer, establishing the modifications to be made, including items to be purchased or rented.
(2) Sixty days after the worker is declared permanent and stationary and is still employed by the employer, the employer may request reimbursement up to $5,000.00 by submitting to the insurer a legible copy of an invoice or receipt indicating "paid" for the items purchased. Reimbursement shall be made for only those items listed in the Worksite Modification Agreement.

(f) The insurer shall not purchase directly or otherwise assume responsibility for Worksite Modifications.

(g) Reimbursed Worksite Modification costs are claims costs.

(h) All requests for reimbursement shall be made within one year of the declaration of permanent and stationary.

Labor Code section 4062.9 Repeal of Treating Physician's Presumption for Pre-Designated Physicians regarding Medical Treatment

SEC. _____. Section 4062.9 of the Labor Code is amended to read:

4062.9 (a) In cases where an additional comprehensive medical evaluation is obtained under Section 4061 or 4062, if the employee has been treated by his or her personal physician, or by his or her personal chiropractor, as defined in Section 4601, who was predesignated prior to the date of injury as provided under Section 4600, the findings of the personal physician or personal chiropractor are presumed to be correct. This presumption is rebuttable and may be controverted by a preponderance of medical opinion indicating a different level of disability. However, the presumption shall not apply where both parties select qualified medical examiners.…

(b)~~In all cases other than those specified in subdivision (a), r~~Regardless of the date of injury, no presumption shall apply to the opinion of any treating physician on the issue of extent and scope of medical treatment, either prior or subsequent to the issuance of an award, compensability, or disability rating.

(c) The administrative director shall develop, not later than January 1, 2004, and periodically revise as necessary thereafter, educational materials to be used to provide treating physicians and chiropractors with information and training in basic concepts of workers' compensation, the role of the treating physician, the importance of a treatment plan to speed return to work and norms for disability durations for the 15 most common workplace injuries, the conduct of permanent and stationary evaluations, and report writing.

(d) The amendments made to this section by SB 228 of the 2003-2004 Regular Session and by SB XXX of the 2003-2004 Special Session shall not constitute good cause to reopen or rescind, alter, or amend any order, decision, or award of the appeals board.

Labor Code section 5307.27 – Disability Duration Norms

SEC. _____. Section 5307.27 of the Labor Code is amended to read:

On or before December 1, 2004, the administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt, after public hearings, a medical treatment utilization schedule, that shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission pursuant to Section 77.5, and that shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases. Additionally, the administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt a disability duration guideline or norm for the 15 most common injuries in the California workers' compensation system; however, the guideline or norm may be based on data from other states.

REGULATION AND ASSESSMENT

Problem: In 1995, California's workers' compensation insurance market was radically deregulated. This led to a traditional insurance cycle of low premiums and excess capacity followed by high prices and restricted capacity. In the past few years, 27 workers' compensation insurance companies have become insolvent as a result of the price wars that evolved out of the deregulated market. California's workers' compensation insurance market is now uncompetitive with unsustainably high premiums that are driving companies out of business and out of the state. Both employers and insurers need stable and predictable workers' compensation insurance rates. Injured workers need to be certain that there will be a source for payment for industrial injuries, in some cases for many years to come. It also became apparent after extensive reform of California's worker's compensation system in 2003 that there is no mechanism in the current system to ensure savings from legislative reform would be passed through directly to policyholders.

Solution: CDI is proposing adoption of the key proposal from the 1992 Rate Study Commission - a mandatory minimum loss cost rate coupled with a uniform classification system. Unlike the pre-1995 Minimum Rate Law, a minimum loss cost law would not allow the Insurance Commissioner to set fixed rates for insurance company expenses. This reform will help stabilize California's workers' compensation market by creating a reasonable price floor and a benchmark for price comparison, flattening out unpredictable insurance cycles that helped create the current crisis, and provide a mechanism for passing through reform savings, not just for one year, but for the long term. We also support an assessment on deductible policies which will help bolster the California Insurance Guarantee Fund (CIGA) and bring more equity to policyholders.

SEC. _____. added to the Insurance Code to read:

Within 90 days of the effective date of this legislation and on January 1st, annually thereafter for the following two calendar years, all admitted workers' compensation insurers shall provide a report to the Insurance Commissioner detailing the specific actions undertaken by their management to implement provisions of Assembly Bill 227, Senate Bill 228 of the Statute and the provisions of this act. Such report shall include the actual results of such implementation activities and an assessment of realized cost savings, as well as any barriers identified to achieving effective cost savings. Insurers may contract with a licensed insurance rating organization in producing any reports required by this section.

Insurance Code Section 11731.5

Mandatory Minimum Loss Cost Rate

SEC. _____. Section 11731.5 of the Insurance Code is added to read:

11731.5. (a) The commissioner shall approve or issue as adequate for all admitted workers' compensation insurers, a classification of risks and pure premium rates for workers'

compensation insurance. Such classification and pure premium rates shall be uniform as to all insurers affected. An insurer may add an expense provision to the approved pure premium rates.
(b) An insurer may not use a rate that is lower than the pure premium rate approved pursuant to paragraph (a) unless such rate is first approved by the commissioner. The insurer shall have the burden of proving that the rate is adequate. The commissioner shall approve such rate if he or she finds that it is adequate to cover the insurer's losses and expenses.
(c) In approving or issuing a classification of risks and pure premium rates under this article, the commissioner shall consider the reduction in workers' compensation costs arising from changes in the law enacted during the 2003-2004 Regular Session and thereafter.

Insurance Code Section 11735

Uniform Classification System

SEC. _____. Section 11735 of the Insurance Code is amended to read:

Amend: Section 11735 (d)

(d) Notwithstanding Section 679.70, no rating organization may issue, nor may any insurer use~~,~~ any ~~classification system or~~ rate, that, as applied or used~~, that~~ violates Section 679.71 or 679.72 or that violates the Unruh Civil Rights Act

Repeal Section 11735.1 of the Insurance Code

~~11735.1. (a) In determining the advisory pure premium rates for policies incepting on or after January 1, 2004, pursuant to a hearing required by subdivision (b) of Section 11750, the Insurance Commissioner shall take into account projected savings due to changes enacted in the 2003-04 Regular Session. (b) Insurers shall file rates to apply to policies incepting on or after January 1, 2004, that include the provision for projected savings determined by the Insurance Commissioner pursuant to subdivision (a), provided, however, that these rates shall comply with Section 11732. (c) This section shall remain in effect only until January 1, 2005, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2005, deletes or extends that date.~~

Insurance Code Section 1063.5

CIGA Deductibles

SEC. __. Section 1063.5 of the Insurance Code is amended to read:

1063.5. Each time an insurer becomes insolvent then, to the extent necessary to secure funds for the association for payment of covered claims of that insolvent insurer and also for payment of reasonable costs of adjusting the claims, the association shall collect premium payments from its member insurers sufficient to discharge its obligations. The association shall allocate its claim payments and costs, incurred or estimated to be incurred, to one or more of the following categories: (a) workers' compensation claims; (b) homeowners' claims, and automobile claims,

which shall include: automobile material damage, automobile liability (both personal injury and death and property damage), medical payments and uninsured motorist claims; and (c) claims other than workers' compensation, homeowners', and automobile, as above defined. Separate premium payments shall be required for each category. The premium payments for each category shall be used to pay the claims and costs allocated to that category. The rate of premium charged shall be a uniform percentage of net direct written premium in the preceding calendar year applicable to that category. The rate of premium charges to each member in the appropriate categories shall initially be based on the written premium of each insurer as shown in the latest year's annual financial statement on file with the commissioner, or in such additional financial information as requested by the association or the commissioner from member insurers. The initial premium shall be adjusted by applying the same rate of premium charge as initially used to each insurer's written premium as shown on the annual statement for the second year following the year in which the initial premium charge is made. The difference between the initial premium charge and the adjusted premium charge shall be charged or credited to each member insurer by the association as soon as practical after the filing of the annual statements of the member insurers with the commissioner for the year on which the adjusted premium is based. In the case of an insurer that was a member insurer when the initial premium charge was made and that paid the initial assessment but is no longer a member insurer at the time of the adjusted premium charge by reason of its insolvency or its withdrawal from the state and surrender of its certificate of authority to transact insurance in this state, any credit accruing to that insurer shall be refunded to it by the association. For all categories except workers' compensation claims, "net direct written premiums" shall mean the amount of gross premiums, less return premiums, received in that calendar year upon business done in this state, other than premiums received for reinsurance. As respects the workers' compensation claims category, "net direct written premiums" shall be increased by the amount of any deductible credit (as reflected in accordance with Section 11735 (e)(5)) on policies written during that calendar year. In cases of a dispute as to the amount of the net direct written premium between the association and one of its members the written decision of the commissioner shall be final. The premium charged to any member insurer for any of the three categories or a category established by the association shall not be more than 2 percent of the net direct premium written in that category in this state by that member per year, starting on January 1, 2003, until December 31, 2007, and thereafter shall be one percent per year. The association may exempt or defer, in whole or in part, the premium charge of any member insurer, if the premium charge would cause the member insurer' s financial statement to reflect an amount of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment, no dividends shall be paid to shareholders or policyholders by the company whose premium charge was deferred. Deferred premium charges shall be paid when the payment will not reduce capital or surplus below required minimums. These payments shall be credited against future premium charges to those companies receiving larger premium charges by virtue of the deferment. After all covered claims of the insolvent insurer and expenses of administration have been paid, any unused premiums and any reimbursements or claims dividends from the liquidator remaining in any category shall be retained by the association and applied to reduce future premium charges in the appropriate category. However, an insurer which ceases to be a member of the association, other than an insurer that has become insolvent or has withdrawn from the state and has surrendered its certificate of authority following an initial assessment that is entitled to a refund based upon an

adjusted assessment as provided above in this section, shall have no right to a refund of any premium previously remitted to the association. The commissioner may suspend or revoke the certificate of authority to transact business in this state of a member insurer which fails to pay a premium when due and after demand has been made.

Interest at a rate equal to the current federal reserve discount rate plus 21/2 percent per annum shall be added to the premium of any member insurer which fails to submit the premium requested by the association within 30 days after the mailing request. However, in no event shall the interest rate exceed the legal maximum.

INTEGRATED SYSTEM CARVE OUT PILOT

Problem: Employers currently pay for workers' compensation medical costs which account for close to 60% of workers' compensation premiums or an estimated $13.8 billion in 2004. In addition to the portion of workers' compensation insurance premium to cover medical costs, most employers also pay for health care benefits for their employees. Despite the overlapping coverage, workers can suffer from lack of prompt medical treatment arising from causation questions; this delay can exacerbate injuries and instigate litigation.

Solution: Currently, qualified joint union-employer "carve-outs" can negotiate a customized workers' comp system for covered employees that utilizes the health care already provided as a benefit. This proposal would allow the establishment of a pilot program for seamless health, workers' comp and non-occupational disability benefit delivery in qualifying carve-outs, without regard to the cause of the sickness or disability. It would be administered by a single administrator at a single location in order to limit costs. Thus, costs and delay should be minimized. The pilot will be evaluated to determine objectively whether it should be expanded.

Labor Code Sections 3201.1 and 3201.2

SEC. 1. Section 3201.1 is added to the Labor Code, to read:

3201.1 (a) It is the policy of the Legislature to improve the workers' compensation, health care delivery, and non-occupational disability systems by promoting prompt and efficient delivery of high-quality medical care and disability compensation.

(b) In furtherance of this policy it is the intent of the Legislature to determine whether it is feasible to establish a seamless health and disability system providing medical care and disability benefits to sick or disabled employees, administered by a single administrator at a single location, without regard to the cause of the sickness or disability.

(c) In furtherance of the policy and intent expressed in subdivisions (a) and (b), commencing January 1, 2005, there is established a heath care and disability pilot program. The pilot program established under this section shall have all of the following elements:

(1) Except as otherwise provided in this section, the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any provision in a collective bargaining agreement between an employer or group of employers and a union that is, or unions that are, the recognized or certified exclusive bargaining representative or representatives that establishes any of the following:

(A) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbitrator or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a

final order, decision, or award made and filed by a workers' compensation administrative law judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

(B) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.

(C) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of medical evaluators and agreed medical evaluators under this division.

(D) Joint labor management safety committees.

(E) A light-duty, modified job, or return-to-work program.

(2) Notwithstanding any other provision of this division or Division 1 (commencing with Section 50), the parties may negotiate any aspect of the delivery of medical benefits and disability compensation to employees of the employer or group of employers that are eligible for group health benefits and non-occupational disability benefits through their employer.

(3) No agreement authorized by paragraphs (1) and (2) shall deny to any employee the right to representation by counsel during all stages of the alternative dispute resolution process. The portion of any agreement that violates this subdivision shall be declared null and void.

(4) To be eligible to participate in the health care and disability pilot program established by this section, an employer or group of employers is required to be one of the following:
(A) An employer developing or projecting an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) or more, or any employer that paid an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000), in at least one of the previous three years.
(B) Group of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, which develops or projects annual workers' compensation insurance premiums of two million dollars ($2,000,000) or more.
(C) Employer or a group of employers that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.

(5) To be eligible to participate in the health care and disability pilot program established by this section, a union is required to satisfy all of the following:
(A) Actually represent employees as to wages, hours and working conditions.
(B) Have officers that have been elected by secret ballot or otherwise in a manner consistent with federal law.

(C) Be free of domination or interference by any employer and have received no improper assistance or support from any employer.

(6) No collective bargaining agreement pursuant to this section shall go into effect until the administrative director has issued a letter advising each employer and labor representative that each has met the eligibility requirements of this section.

(7) Employees of the employer or group of employers shall be subject to the provision of the collective bargaining agreement authorized by paragraph (1) of subdivision (c) only as long as the employee remains an employee of the employer or group of employers. On termination of the employment, the employee shall be eligible for the same workers' compensation, group health, and non-occupational disability benefits to which he or she was entitled before the effective date of the agreement.

(d) This section shall become inoperative on January 1, 2010, and, as of January 1, 2010, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2010, deletes or extends the dates on which the section becomes inoperative and is repealed.

SEC.2. Section 3201.2 is added to the Labor Code, to read:

3201.2. (a) Not later than June 30, 2008, and annually thereafter, the Commission on Health and Safety and Workers' Compensation shall prepare and publish a report based on aggregate data that shall include all of the following information with respect to the pilot program provided for pursuant to Section 3201.1:

(1) Person hours and payroll covered by any agreement or agreements executed pursuant to Section 3201.1.

(2) The number of claims filed.

(3) The average cost per claim.

(4) The number of litigated claims, including the number of claims submitted each to mediation, arbitration, the appeals board, and the court of appeal.

(5) The number of contested claims resolved prior to arbitration.

(6) The total projected incurred costs and actual costs of claims.

(7) Safety history.

(8) Return to work results.

(9) The average time from knowledge of sickness or disability to initiation of medical treatment.

(10) The average time from knowledge of disability to first payment of compensation.

(11) Complaints from employees and providers.

(12) Quality of care.

(13) Comparable available data from employers and insurers not participating in the pilot program.

(b) The commission may require any employer or group of employers participating in a pilot program authorized by Section 3201.1 to provide the data necessary to prepare the report.

(c) The data obtained by the commission pursuant to this section shall be confidential and not be subject to public disclosure under any law of this state. However, the commission may create derivative works based on the collective bargaining agreements and data that do not identify any employee or provider. Those derivative works shall not be confidential, but shall be subject to public disclosure.